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As a courtesy, I offer my patients the option for their assessment fees to be billed directly to their credit card. This form authorizes Melissa Procker Sorci, Ph.D. to bill your credit card for services on the last billing date of each month. This information is kept confidential and private. Please complete all information below.

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Today's date:

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Name on Card:

_____

Circle: Visa MasterCard

Card #:

_____

Expiration Date: _____

Patient Name:

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Billing Address:

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Zip Code:_____

➔ SIGNATURE:

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